

		FOR OHF USE					

LL 1

2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0041442</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Lyncrest Manor of Paris</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/02</u> to <u>12/31/02</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>310 Eads Avenue</u> <u>Paris</u> <u>61944</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>Edgar</u>		(Signed) _____ (Date) _____	
Telephone Number: <u>(217) 465-5395</u> Fax # <u>(217) 463-2242</u>		(Type or Print Name) _____	
IDPA ID Number: <u>371346156004</u>		(Title) _____	
Date of Initial License for Current Owners: <u>04/01/96</u>		(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____	
Type of Ownership:		(Print Name and Title) _____	
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____		(Firm Name & Address) <u>Altschuler, Melvoin and Glasser, LLP</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u>	
<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____		(Telephone) <u>(312) 634-3400</u> Fax # <u>(312) 634-5518</u>	
<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
In the event there are further questions about this report, please contact: Name: <u>Christine Hanover</u> Telephone Number: <u>(312) 634-3400</u> Please send copies of desk review and audit adjustments to address on this page			

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lynncrest Manor of Paris# 0041442 Report Period Beginning: 01/01/02 Ending: 12/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>62</u>	Skilled (SNF)	<u>62</u>	<u>22,630</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>62</u>	TOTALS	<u>62</u>	<u>22,630</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF			<u>744</u>	<u>744</u>	8
9	SNF/PED					9
10	ICF	<u>12,393</u>	<u>3,129</u>		<u>15,522</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>12,393</u>	<u>3,129</u>	<u>744</u>	<u>16,266</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 71.88%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☒NO ☐Non-allowable costs have been
eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐NO ☒

I. On what date did you start providing long term care at this location?

Date started 04/01/96

J. Was the facility purchased or leased after January 1, 1978?

YES ☒Date 02/98NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒NO ☐If YES, enter number
of beds certified 8 and days of care provided 744Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 12/31/02 Fiscal Year: 12/31/02

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 3

Facility Name & ID Number Lyncrest Manor of Paris # 0041442 Report Period Beginning: 01/01/02 Ending: 12/31/02**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	81,451	6,632	4,849	92,932		92,932		92,932			1
2	Food Purchase		64,503		64,503		64,503	(200)	64,303			2
3	Housekeeping	46,443	6,520		52,963		52,963		52,963			3
4	Laundry	34,841	8,649		43,490		43,490		43,490			4
5	Heat and Other Utilities			43,991	43,991		43,991	776	44,767			5
6	Maintenance	17,387		29,760	47,147		47,147	44	47,191			6
7	Other (specify):*											7
8	TOTAL General Services	180,122	86,304	78,600	345,026		345,026	620	345,646			8
	B. Health Care and Programs											
9	Medical Director			6,900	6,900		6,900		6,900			9
10	Nursing and Medical Records	544,448	46,056	3,556	594,060		594,060		594,060			10
10a	Therapy			120,029	120,029		120,029		120,029			10a
11	Activities	15,324	2,875	1,795	19,994		19,994		19,994			11
12	Social Services	18,238		1,795	20,033		20,033		20,033			12
13	Nurse Aide Training											13
14	Program Transportation			1,661	1,661		1,661		1,661			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	578,010	48,931	135,736	762,677		762,677		762,677			16
	C. General Administration											
17	Administrative	51,329		(40,717)	10,612		10,612	40,717	51,329			17
18	Directors Fees											18
19	Professional Services			20,875	20,875		20,875	15,729	36,604			19
20	Dues, Fees, Subscriptions & Promotions			3,997	3,997		3,997	(285)	3,712			20
21	Clerical & General Office Expenses	127,793	9,957	15,017	152,767		152,767	5,350	158,117			21
22	Employee Benefits & Payroll Taxes			145,577	145,577		145,577	8,879	154,456			22
23	Inservice Training & Education			30	30		30	168	198			23
24	Travel and Seminar			2,221	2,221		2,221	2,057	4,278			24
25	Other Admin. Staff Transportation			1,201	1,201		1,201		1,201			25
26	Insurance-Prop.Liab.Malpractice			32,831	32,831		32,831	4,705	37,536			26
27	Other (specify):*											27
28	TOTAL General Administration	179,122	9,957	181,032	370,111		370,111	77,320	447,431			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	937,254	145,192	395,368	1,477,814		1,477,814	77,940	1,555,754			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

**See schedule of adjustments attached at end of cost report.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			5,701	5,701		5,701	88,705	94,406			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			54,459	54,459		54,459	148,541	203,000			32
33	Real Estate Taxes							28,092	28,092			33
34	Rent-Facility & Grounds			276,000	276,000		276,000	(271,901)	4,099			34
35	Rent-Equipment & Vehicles			4,174	4,174		4,174	3,845	8,019			35
36	Other (specify):* MIP Expense							9,546	9,546			36
37	TOTAL Ownership			340,334	340,334		340,334	6,828	347,162			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		22,604		22,604		22,604		22,604			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			34,028	34,028		34,028		34,028			42
43	Other (specify):* Nonallowable Costs			34,080	34,080		34,080	(34,080)				43
44	TOTAL Special Cost Centers		22,604	68,108	90,712		90,712	(34,080)	56,632			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	937,254	167,796	803,810	1,908,860		1,908,860	50,688	1,959,548			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

** See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lyncrest Manor of Paris# 0041442Report Period Beginning: 01/01/02Ending: 12/31/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	1	2	3	
	Amount	Refer-	OHF USE	
		ence	ONLY	
NON-ALLOWABLE EXPENSES				
1 Day Care	\$		\$	1
2 Other Care for Outpatients				2
3 Governmental Sponsored Special Programs				3
4 Non-Patient Meals	(200)	2		4
5 Telephone, TV & Radio in Resident Rooms	(509)	43		5
6 Rented Facility Space				6
7 Sale of Supplies to Non-Patients				7
8 Laundry for Non-Patients				8
9 Non-Straightline Depreciation	(3,229)	30		9
10 Interest and Other Investment Income	(10)	32		10
11 Discounts, Allowances, Rebates & Refunds				11
12 Non-Working Officer's or Owner's Salary				12
13 Sales Tax	(640)	43		13
14 Non-Care Related Interest				14
15 Non-Care Related Owner's Transactions				15
16 Personal Expenses (Including Transportation)				16
17 Non-Care Related Fees				17
18 Fines and Penalties	(10,021)	43		18
19 Entertainment				19
20 Contributions	(308)	43		20
21 Owner or Key-Man Insurance				21
22 Special Legal Fees & Legal Retainers				22
23 Malpractice Insurance for Individuals				23
24 Bad Debt	(19,760)	43		24
25 Fund Raising, Advertising and Promotional	(2,497)	43		25
26 Income Taxes and Illinois Personal Property Replacement Tax				26
27 Nurse Aide Training for Non-Employees				27
28 Yellow Page Advertising				28
29 Other-Attach Schedule See Attached Schedule 5A	(630)			29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (37,804)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

	1	2	
	Amount	Reference	
31 Non-Paid Workers-Attach Schedule*	\$		31
32 Donated Goods-Attach Schedule*			32
33 Amortization of Organization & Pre-Operating Expense			33
34 Adjustments for Related Organization Costs (Schedule VII)	88,492		34
35 Other- Attach Schedule			35
36 SUBTOTAL (B): (sum of lines 31-35)	\$ 88,492		36
(sum of SUBTOTALS			
37 TOTAL ADJUSTMENTS (A) and (B))	\$ 50,688		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.
(See instructions.)

	1	2	3	4	
	Yes	No	Amount	Reference	
38 Medically Necessary Transport.		x	\$		38
39					39
40 Gift and Coffee Shops		x			40
41 Barber and Beauty Shops		x			41
42 Laboratory and Radiology		x			42
43 Prescription Drugs		x			43
44 Exceptional Care Program		x			44
45 Other-Attach Schedule		x			45
46 Other-Attach Schedule		x			46
47 TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Lynncrest Manor of ParisID# 0041442Report Period Beginning: 01/01/02Ending: 12/31/02

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Lab Part A	\$	(345)	43
2	Nonallowable PAC Dues		(285)	20
3				
4				
5				
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47				
48				
49	Total		(630)	

See Accountants' Compilation Report

Summary A

12/31/02

[illegible]

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lyncrest Manor of Paris# 0041442

Report Period Beginning:

01/01/02

Ending:

12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(3,229)	994	90,940	0	0	0	0	0	0	0	0	88,705	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(10)	6,976	141,575	0	0	0	0	0	0	0	0	148,541	32
33	Real Estate Taxes	0	0	28,092	0	0	0	0	0	0	0	0	28,092	33
34	Rent-Facility & Grounds	0	4,099	(276,000)	0	0	0	0	0	0	0	0	(271,901)	34
35	Rent-Equipment & Vehicles	0	3,845	0	0	0	0	0	0	0	0	0	3,845	35
36	Other (specify):*	0	0	9,546	0	0	0	0	0	0	0	0	9,546	36
37	TOTAL Ownership	(3,239)	15,914	(5,847)	0	0	0	0	0	0	0	0	6,828	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(34,080)	0	0	0	0	0	0	0	0	0	0	(34,080)	43
44	TOTAL Special Cost Centers	(34,080)	0	0	0	0	0	0	0	0	0	0	(34,080)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(37,804)	77,860	10,632	0	0	0	0	0	0	0	0	50,688	45

Facility Name & ID Number Lyncrest Manor of Paris# 0041442

Report Period Beginning:

01/01/02

Ending:

12/31/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
DSI Partners, L.L.C.	100%	Lyncrest Manor of Auburn	Auburn	DSI Management Services, Inc.	Peoria	Management Co.
(owned 70% by Jerry Neal, and 15% each by Sherry Borum-Neal and Ronald Mangum)						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5 Utilities	\$	DSI Management Services, Inc.	A	\$ 776	\$ 776	1
2	V	6 Maintenance Supplies		DSI Management Services, Inc.	A	44	44	2
3	V	17 Management Fees	(40,717)	DSI Management Services, Inc.	A		40,717	3
4	V	19 Professional Services		DSI Management Services, Inc.	A	3,924	3,924	4
5	V	21 Clerical & General Office Exp.		DSI Management Services, Inc.	A	5,226	5,226	5
6	V	22 Employee Benefits		DSI Management Services, Inc.	A	8,879	8,879	6
7	V	23 Inservice Training & Education		DSI Management Services, Inc.	A	168	168	7
8	V	24 Travel & Seminar		DSI Management Services, Inc.	A	2,057	2,057	8
9	V	26 Insurance - Prop. Liability		DSI Management Services, Inc.	A	155	155	9
10	V	30 Depreciation		DSI Management Services, Inc.	A	994	994	10
11	V	32 Interest		DSI Management Services, Inc.	A	6,976	6,976	11
12	V	34 Rent - Facility & Grounds		DSI Management Services, Inc.	A	4,099	4,099	12
13	V	35 Rent - Equipment & Vehicles		DSI Management Services, Inc.	A	3,845	3,845	13
14	Total		\$ (40,717)			\$ 37,143	\$ *	77,860 14

* Total must agree with the amount recorded on line 34 of Schedule VI.

A: Owned 100% by Jerry Neal

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lyncrest Manor of Paris# 0041442Report Period Beginning: 01/01/02Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	19 Professional Services	\$	Lyncrest Realty Associates of Paris	100.00%	\$ 11,805	\$ 11,805
16	V	21 Clerical & General Office Expense		Lyncrest Realty Associates of Paris	100.00%	124	124
17	V	26 Insurance		Lyncrest Realty Associates of Paris	100.00%	4,550	4,550
18	V	30 Depreciation		Lyncrest Realty Associates of Paris	100.00%	90,940	90,940
19	V	32 Interest		Lyncrest Realty Associates of Paris	100.00%	141,575	141,575
20	V	33 Real Estate Taxes		Lyncrest Realty Associates of Paris	100.00%	28,092	28,092
21	V	34 Rent - Facility and Grounds	276,000	Lyncrest Realty Associates of Paris	100.00%		(276,000)
22	V	36 MIP Expense		Lyncrest Realty Associates of Paris	100.00%	9,546	9,546
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 276,000			\$ 286,632	\$ * 10,632

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lyncrest Manor of Paris # 0041442 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5				N/A							5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lyncrest Manor of Paris# 0041442 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization DSI Management Services, Inc.
 Street Address 4239 War Memorial Drive
 City / State / Zip Code Peoria, IL 61614
 Phone Number (309) 685-0595
 Fax Number (309) 685-9596

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Number of Beds	132	2	\$ 1,653	\$ 62	\$ 776	1
2	6	Maintenance	Number of Beds	132	2	94	62	44	2
3	19	Professional Services	Number of Beds	132	2	8,355	62	3,924	3
4	21	Clerical & Gen. Office Exp.	Number of Beds	132	2	11,127	62	5,226	4
5	22	Employee Benefits	Number of Beds	132	2	18,904	62	8,879	5
6	23	Inservice Training & Education	Number of Beds	132	2	358	62	168	6
7	24	Travel & Seminar	Number of Beds	132	2	4,380	62	2,057	7
8	26	Insurance - Property Liability	Number of Beds	132	2	331	62	155	8
9	30	Depreciation	Number of Beds	132	2	2,116	62	994	9
10	32	Interest	Number of Beds	132	2	14,853	62	6,976	10
11	34	Rent - Facility & Grounds	Number of Beds	132	2	8,727	62	4,099	11
12	35	Rent - Equipment & Vehicles	Number of Beds	132	2	8,186	62	3,845	12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 79,084	\$	\$ 37,143	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lynncrest Manor of Paris# 0041442

Report Period Beginning:

01/01/02

Ending:

12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3		4		5		6		7		8		9		10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense								
		YES	NO				Original	Balance											
	A. Directly Facility Related																		
	Long-Term																		
1	Huntoon Paige/Prudential		X	Mortgage	\$13,151.00	01/22/98	\$ 1,900,000	\$ 1,842,077	02/01/33	0.0775	\$ 143,093	1							
2	Carol Fleming		X	Loan	\$4,231.00	02/02/98	300,000	212,734	07/01/06	0.0900	13,772	2							
3	NCS Lease		X	Hardware/Software	\$505.00	10/31/98	20,207	11,553	09/30/03	0.1429		3							
4	Southe Pointe		X	Improvement	\$1,810.00	12/27/01	73,413	61,398	12/27/02	P+.0200	17,486	4							
5												5							
	Working Capital																		
6								Amortization of Loan Costs			3,126	6							
7												7							
8												8							
9	TOTAL Facility Related				\$19,697.00		\$ 2,293,620	\$ 2,127,762			\$ 177,477	9							
	B. Non-Facility Related*																		
10								Allocated from DSI Management Svc.			6,976	10							
11								Miscellaneous Interest			18,547	11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$ 25,523	14							
15	TOTALS (line 9+line14)						\$ 2,293,620	\$ 2,127,762			\$ 203,000	15							

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 9,546 Line # 36* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **Lyncrest Manor of Paris**# **0041442**

Report Period Beginning:

01/01/02

Ending:

12/31/02**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

<div style="border: 1px solid black; padding: 2px; display: inline-block;"> Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report. </div>																											
1. Real Estate Tax accrual used on 2001 report.		\$	28,610																								
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2001	\$	28,351																								
3. Under or (over) accrual (line 2 minus line 1).		\$	(259)																								
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	28,351																								
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$																									
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$																									
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	28,092																								
Real Estate Tax History:																											
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>1997</td><td style="text-align: right;">11,751</td><td style="text-align: center;">8</td></tr> <tr><td>1998</td><td style="text-align: right;">11,241</td><td style="text-align: center;">9</td></tr> <tr><td>1999</td><td style="text-align: right;">31,672</td><td style="text-align: center;">10</td></tr> <tr><td>2000</td><td style="text-align: right;">28,610</td><td style="text-align: center;">11</td></tr> <tr><td>2001</td><td style="text-align: right;">28,351</td><td style="text-align: center;">12</td></tr> </table>	1997	11,751	8	1998	11,241	9	1999	31,672	10	2000	28,610	11	2001	28,351	12	<table border="1"> <tr><td colspan="2" style="text-align: center;">FOR OHF USE ONLY</td></tr> <tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2001 \$</td></tr> <tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5 \$</td></tr> <tr><td>15</td><td>LESS REFUND FROM LINE 6 \$</td></tr> <tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION \$</td></tr> </table>	FOR OHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2001 \$	14	PLUS APPEAL COST FROM LINE 5 \$	15	LESS REFUND FROM LINE 6 \$	16	AMOUNT TO USE FOR RATE CALCULATION \$
1997	11,751	8																									
1998	11,241	9																									
1999	31,672	10																									
2000	28,610	11																									
2001	28,351	12																									
FOR OHF USE ONLY																											
13	FROM R. E. TAX STATEMENT FOR 2001 \$																										
14	PLUS APPEAL COST FROM LINE 5 \$																										
15	LESS REFUND FROM LINE 6 \$																										
16	AMOUNT TO USE FOR RATE CALCULATION \$																										
Real estate tax accrual is based on 100% of prior year's tax bill.																											

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lyncrest Manor of Paris COUNTY Edgar

FACILITY IDPH LICENSE NUMBER 0041442

CONTACT PERSON REGARDING THIS REPORT Allan Herrmann

TELEPHONE (309) 685-0595 FAX #: (309) 685-9596

A. Summary of Real Estate Tax Costs

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	09-19-06-300-018	Nursing Facility	\$ 28,351.00	\$ 28,351.00
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ <u>28,351.00</u>	\$ <u>28,351.00</u>

B. Real Estate Tax Cost Allocation:

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used)

C. Tax Bills

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

A.

Square Feet:

14,020

B.

General Construction Type:

Exterior

Concrete

Frame

Number of Stories

One

C.

Does the Operating Entity?

☐ (a) Own the Facility
 ☒ (b) Rent from a Related Organization.
 ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D.

Does the Operating Entity?

☒ (a) Own the Equipment
 ☒ (b) Rent equipment from a Related Organization.
 ☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E.

List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground: (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F.

Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES
 ☒ NO

If so, please complete the following:

1. Total Amount Incurred:

N/A

2. Number of Years Over Which it is Being Amortized:

N/A

3. Current Period Amortization:

N/A

4. Dates Incurred:

N/A

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Patient Care	128,700	1998	\$ 25,850	1
2					2
3	TOTALS	128,700		\$ 25,850	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lynncrest Manor of Paris# 0041442

Report Period Beginning:

01/01/02

Ending:

12/31/02**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar**

	1 Beds*	2 FOR OHF USE ONLY	3 Year Acquired	4 Year Constructed	5 Cost	6 Current Book Depreciation	7 Life in Years	8 Straight Line Depreciation	9 Adjustments	10 Accumulated Depreciation	
4	62		1998	1977	\$ 1,536,550	\$	40	\$ 38,414	\$ 38,414	\$ 188,868	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Air Conditioner		1996		552		10	55	55	351	9
10	Roof Repair		1996		3,770		20	188	188	1,246	10
11	Smoke Detectors		1997		3,580		15	239	239	1,434	11
12	Air Conditioner		1997		789		10	79	79	441	12
13	Plumbing		1997		2,555		15	170	170	949	13
14	Remodeling		1997		723		15	48	48	244	14
15	2 Air Conditioners		1997		1,105		10	111	111	615	15
16	Asbestos Removal		1998		15,112		15	1,007	1,007	4,687	16
17	Floor Tile		1998		24,517		15	1,634	1,634	7,396	17
18	Electric Wiring		1998		5,272		15	351	351	1,433	18
19	Water Heater		1998		8,000		15	533	533	2,532	19
20	Plumbing		1999		625	42	15	42		147	20
21	Security Alarm Doors		1999		2,836	189	15	189		662	21
22	Security Alarm Horns		1999		785	52	15	52		182	22
23	Sprinkler System		1999		6,855	457	15	457		1,600	23
24	Carpentry on ceiling		1999		2,950		15	197	197	689	24
25	Security Horns and Detectors		1999		3,180		15	212	212	742	25
26	Upgrade fire alarm system		1999		5,810		15	387	387	1,355	26
27	Heaters		1999		2,036		15	136	136	476	27
28	Sprinkler System		1999		55,627		15	3,708	3,708	12,978	28
29	Roofing		1999		10,500		15	700	700	2,450	29
30	Electric Wiring		1999		3,356		15	224	224	784	30
31	Cabinets		1999		3,036		15	202	202	707	31
32	Handrail		1999		7,338		15	490	490	1,713	32
33	Lumber		1999		1,702		15	113	113	396	33
34	Progress Light		1999		1,700		15	113	113	396	34
35	Electric Wiring/Fire Alarm		2000		5,586	328	15	328		945	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 12A

Facility Name & ID Number Lyncrest Manor of Paris# 0041442

Report Period Beginning:

01/01/02

Ending:

12/31/02

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar**

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Sprinkler System	2000	\$ 7,239	\$	15	\$ 483	\$ 483	\$ 1,449		37
38	Window Treatments	2000	350		10	35	35	105		38
39	Carpeting	2000	1,383		15	92	92	276		39
40	Asphalt Paving	2000	9,850		15	657	657	1,971		40
41	Lumber for Doors	2000	3,280		15	219	219	657		41
42	Roof Repair	2000	3,178		15	212	212	636		42
43	Smoke Detectors	2000	5,571		15	371	371	1,113		43
44	Sprinklers	2001	9,582		15	639	639	925		44
45	Remodel Bathrooms	2001	17,341		15	1,156	1,156	1,723		45
46	Heating Architect Designs	2001	18,500		15	1,233	1,233	1,644		46
47	Fire Alarms	2001	6,977		15	465	465	543		47
48	Nurse Call Station	2001	17,940		15	1,196	1,196	1,394		48
49	Remodeling of Resident Closets	2001	1,357		15	90	90	98		49
50	Sewer Line	2001	1,000	67	15	67		89		50
51	Remodeling Bathrooms	2002	2,929		15	98	98	98		51
52	Remodeling Showers	2002	5,193		15	173	173	173		52
53	Remodeling Hallway and Entranceway	2002	1,329		15	49	49	49		53
54										54
55										55
56										56
57										57
58										58
59										59
60										60
61										61
62										62
63										63
64										64
65										65
66										66
67										67
68										68
69										69
70	TOTAL (lines 4 thru 69)		\$ 1,829,446	\$ 1,135		\$ 57,614	\$ 56,479	\$ 249,361		70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 272,882	\$ 1,849	\$ 34,715	\$ 32,866	5-10	\$ 157,001	71
72	Current Year Purchases	1,031	86	52	(34)	10	52	72
73	Fully Depreciated Assets							73
74	Allocated from Management Company			994	994			74
75	TOTALS	\$ 273,913	\$ 1,935	\$ 35,761	\$ 33,826		\$ 157,053	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Care	1993 Ford Van	1996	\$ 7,162	\$ 895	\$ 895		8	\$ 6,042	76
77	Resident Care	A/C Replacement on Van	1999	1,087	136	136		8	465	77
78										78
79										79
80	TOTALS			\$ 8,249	\$ 1,031	\$ 1,031			\$ 6,507	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,137,458	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 4,101	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 94,406	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 90,305	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 412,921	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

10. Effective dates of current rental agreement:

Beginning

Ending _____

11. Rent to be paid in future years under the current rental agreement:

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease .

None

N/A

9. Option to Buy: ☐ YES ☐ NO Terms: _____

15. Is Movable equipment rental included in building rental?

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ 5,019 Description: Dishwasher \$615; Copier \$559; Allocated from Management Company \$3,845

(Attach a schedule detailing the breakdown of movable equipment)

	1	2	3	4	
	Use	Model Year and Make	Monthly Lease Payment	Rental Expense for this Period	
17	Resident Care	1998 Ford Van	\$ 250.00	\$ 3,000	17
18					18
19					19
20					20
21	TOTAL		\$ 250.00	\$ 3,000	21

* If there is an option to buy the building, please provide complete details on attached schedule.

**** This amount plus any amortization of lease expense must agree with page 4, line 34.**

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
--	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		1		2		3	4
		Facility					
		Drop-outs	Completed			Contract	Total
1	Community College Tuition	\$	\$			\$	\$
2	Books and Supplies						
3	Classroom Wages (a)						
4	Clinical Wages (b)						
5	In-House Trainer Wages (c)						
6	Transportation						
7	Contractual Payments						
8	Nurse Aide Competency Tests						
9	TOTALS	\$	\$			\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$					

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.
SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	L10a, C3	hrs	\$	422	\$ 27,398	\$	422	\$ 27,398	1
2	Licensed Speech and Language Development Therapist	L10a, C3	hrs		152	11,701		152	11,701	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10a, C3	hrs		1,245	80,930		1,245	80,930	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescripts				22,604		22,604	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$	1,819	\$ 120,029	\$ 22,604	1,819	\$ 142,633	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Lynncrest Manor of Paris

Provider #: 0041442

01/01/02 to 12/31/02

Schedule 16A

XIV. Special Services

Line 13 Other (specify):

Service	Line Reference	Outside Practioner Units	Cost	Supplies
	L39, C3			
	L39, C3			
	L39, C3			
	L39, C3			
Total			0	0

See Accountants' Compilation Report

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (37,733)	\$ 109,816	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 30,321)	236,137	588,737	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	33,168	32,982	6
7	Other Prepaid Expenses	12,589	14,125	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due from Related Parties	46,112	45,840	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 290,273	\$ 791,500	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		25,850	13
14	Buildings, at Historical Cost	16,687	1,828,446	14
15	Leasehold Improvements, at Historical Cost	1,000	1,000	15
16	Equipment, at Historical Cost	35,478	282,162	16
17	Accumulated Depreciation (book methods)	(24,768)	(412,921)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify) Loan Costs		94,034	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 28,397	\$ 1,818,571	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 318,670	\$ 2,610,071	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 727,619	\$ 767,844	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	46,955	46,955	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,421	3,421	31
32	Accrued Real Estate Taxes(Sch.IX-B)		28,351	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to related Parties	1,149,384	1,256,299	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,927,379	\$ 2,102,870	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	72,282	72,951	39
40	Mortgage Payable	212,734	2,054,811	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 285,016	\$ 2,127,762	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,212,395	\$ 4,230,632	46
47	TOTAL EQUITY (page 18, line 24)	\$ (1,893,725)	\$ (1,620,561)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 318,670	\$ 2,610,071	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,650,940)	1
2	Restatements (describe):		2
3	Prior Period Adjustment	8,919	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,642,021)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(251,704)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (251,704)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,893,725)	24 *

Operating Entity Only

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 19

Facility Name & ID Number Lynncrest Manor of Paris

0041442

Report Period Beginning: 01/01/02

Ending:

12/31/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 1,485,456	1
2	Discounts and Allowances for all Levels	(62,077)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,423,379	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	196,582	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 196,582	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	200	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	33,905	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	488	19
20	Radiology and X-Ray		20
21	Other Medical Services	2,092	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 36,685	23
D. Non-Operating Revenue			
24	Contributions	500	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 500	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	10	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 10	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,657,156	30

2			
	Expenses	Amount	
A. Operating Expenses			
31	General Services	345,026	31
32	Health Care	762,677	32
33	General Administration	370,111	33
B. Capital Expense			
34	Ownership	340,334	34
C. Ancillary Expense			
35	Special Cost Centers	56,684	35
36	Provider Participation Fee	34,028	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,908,860	40
41	Income before Income Taxes (line 30 minus line 40)**	(251,704)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (251,704)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.
This entity files as part of a combined cash basis return.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **Lyncrest Manor of Paris**# **0041442**Report Period Beginning: **01/01/02**Ending: **12/31/02**

12/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,081	2,081	\$ 42,706	\$ 20.52	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,975	6,488	114,607	17.66	3
4	Licensed Practical Nurses	7,414	8,099	116,864	14.43	4
5	Nurse Aides & Orderlies	26,508	27,559	217,296	7.88	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,852	2,073	18,200	8.78	8
9	Activity Director					9
10	Activity Assistants	1,973	2,024	15,324	7.57	10
11	Social Service Workers	1,928	2,082	18,238	8.76	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	11,730	12,255	81,451	6.65	15
16	Dishwashers					16
17	Maintenance Workers	1,708	1,743	17,387	9.98	17
18	Housekeepers	7,288	7,430	46,443	6.25	18
19	Laundry	5,342	5,576	34,841	6.25	19
20	Administrator	2,085	2,085	51,329	24.62	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,726	6,932	127,793	18.44	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	412	435	3,210	7.38	31
32	Other Health Care Plan Coordinators	1,842	2,125	31,565	14.85	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	84,864	88,987	\$ 937,254 *	\$ 10.53	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	92	\$ 4,586	L1, C3	35
36	Medical Director	Monthly	6,900	L9, C3	36
37	Medical Records Consultant	Monthly	680	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	13	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	27	1,795	L11, C3	44
45	Social Service Consultant	27	1,795	L12, C3	45
46	Other(specify) <u>Lab Consultant</u>	Monthly	255	L10, C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	146	\$ 16,024		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses	32	1,278	L10, C3	51
52	Nurse Aides	65	1,330	L10, C3	52
53	TOTAL (lines 50 - 52)	97	\$ 2,608		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lyncrest Manor of Paris

XIX. SUPPORT SCHEDULES

STATE OF ILLINOIS

0041442

Page 21

Report Period Beginning: 01/01/02 Ending: 12/31/02

<p>A. Administrative Salaries</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%;">Name</th> <th style="width: 15%;">Function</th> <th style="width: 10%;">Ownership %</th> <th style="width: 45%;">Amount</th> </tr> </thead> <tbody> <tr> <td><u>Garald Meeks</u></td> <td><u>Administrator</u></td> <td><u>0%</u></td> <td style="text-align: right;">\$ <u>51,329</u></td> </tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr> <td colspan="3">TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)</td> <td style="text-align: right;">\$ <u>51,329</u></td> </tr> </tbody> </table> <p>B. 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Vendor/Payee	Type	Amount																																																																																																																																																																																																									
<u>Advanced Answers</u>	<u>Consulting</u>	\$ <u>2,054</u>																																																																																																																																																																																																									
<u>ADP</u>	<u>Computer Services</u>	<u>4,768</u>																																																																																																																																																																																																									
<u>TigerPaw.com</u>	<u>Computer Services</u>	<u>1,690</u>																																																																																																																																																																																																									
<u>Altschuler, Melvoin</u>	<u>Accounting</u>	<u>9,852</u>																																																																																																																																																																																																									
<u>& Glasser LLP</u>																																																																																																																																																																																																											
<u>American Express Tax</u>	<u>Accounting</u>	<u>2,511</u>																																																																																																																																																																																																									
<u>& Business Services</u>																																																																																																																																																																																																											
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)		\$ <u>20,875</u>																																																																																																																																																																																																									
Description	Amount																																																																																																																																																																																																										
<u>Workers' Compensation Insurance</u>	\$ <u>40,358</u>																																																																																																																																																																																																										
<u>Unemployment Compensation Insurance</u>	<u>7,351</u>																																																																																																																																																																																																										
<u>FICA Taxes</u>	<u>63,432</u>																																																																																																																																																																																																										
<u>Employee Health Insurance</u>	<u>32,586</u>																																																																																																																																																																																																										
<u>Employee Meals</u>																																																																																																																																																																																																											
<u>Illinois Municipal Retirement Fund (IMRF)*</u>																																																																																																																																																																																																											
<u>Employee Physicals</u>	<u>322</u>																																																																																																																																																																																																										
<u>Other Employee Benefits</u>	<u>1,528</u>																																																																																																																																																																																																										
<u>Allocated from Management Company</u>	<u>8,879</u>																																																																																																																																																																																																										
TOTAL (agree to Schedule V, line 22, col.8)	\$ <u>154,456</u>																																																																																																																																																																																																										
Description	Line #	Amount																																																																																																																																																																																																									
<u>N/A</u>																																																																																																																																																																																																											
TOTAL		\$ <u> </u>																																																																																																																																																																																																									
Description	Amount																																																																																																																																																																																																										
<u>IDPH License Fee</u>	\$ <u>200</u>																																																																																																																																																																																																										
<u>Advertising: Employee Recruitment</u>	<u>678</u>																																																																																																																																																																																																										
<u>Health Care Worker Background Check</u> (Indicate # of checks performed <u>54</u>)	<u>378</u>																																																																																																																																																																																																										
<u>Illinois Health Care Association</u>	<u>1,423</u>																																																																																																																																																																																																										
<u>Secretary of State</u>	<u>234</u>																																																																																																																																																																																																										
<u>Misc. Dues & Subscriptions</u>	<u>799</u>																																																																																																																																																																																																										
Less: Public Relations Expense	(<u> </u>)																																																																																																																																																																																																										
Non-allowable advertising	(<u> </u>)																																																																																																																																																																																																										
Yellow page advertising	(<u> </u>)																																																																																																																																																																																																										
TOTAL (agree to Sch. V, line 20, col. 8)	\$ <u>3,712</u>																																																																																																																																																																																																										
Description	Amount																																																																																																																																																																																																										
<u>Out-of-State Travel</u>	\$ <u> </u>																																																																																																																																																																																																										
<u>In-State Travel</u>	<u>1,241</u>																																																																																																																																																																																																										
<u>Seminar Expense</u>	<u>980</u>																																																																																																																																																																																																										
<u>Allocated from Management Company</u>	<u>2,057</u>																																																																																																																																																																																																										
Entertainment Expense	(<u> </u>)																																																																																																																																																																																																										
(agree to Sch. V, line 24, col. 8)																																																																																																																																																																																																											
TOTAL	\$ <u>4,278</u>																																																																																																																																																																																																										

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Lynncrest Manor of Paris
Provider #: 0041442
01/01/02 to 12/31/02

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Total (agree to Schedule V, line 19, column 3)	20,875
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Allocated from Management Company	3,924
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Allocated from Real Estate Entity	11,805
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Total (agree to Schedule V, line 19, column 8)	<u>36,604</u>
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See Accountants' Compilation Report

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2	N/A												
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lyncrest Manor of Paris

STATE OF ILLINOIS

0041442

Report Period Beginning:

01/01/02

Ending:

Page 23

12/31/02

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Illinois Health Care Association \$1,423
- (3) Did the nursing home make political contributions or payments to a political organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 1,837 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 34,028
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit: on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 200
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 58%
d. Have vehicle usage logs been maintained? Adequate records have been maintained.
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

RECONCILIATION REPORT

Lynncrest Manor of Pari

03:26 PM

11/04/05

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB- SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB- SCHED.	LINE NO.	COL. NO.
Adjustment Detail	50,688	equal to	50,688	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	203,000	equal to	203,000	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	28,092	equal to	28,092	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	94,406	equal to	94,406	0	FAILED	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	4,099	equal to	4,099	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	8,019	equal to	8,019	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv. - Staff Wages		equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	120,029	equal to	120,029	0	O.K.	Pg16 Z12+Z14...	N/A/B	1-4,40-43	8;2	Pg3 H20	N/A	10a	4
Special Serv. - Supplies	22,604	equal to	#VALUE!	#VALUE!	#VALUE!	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	345,026	equal to	345,026	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	762,677	equal to	762,677	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	370,111	equal to	370,111	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	340,334	equal to	340,334	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	56,684	equal to	56,684	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+†	N/A	38to41+43	4
Income Stat. Prov. Partic.	34,028	equal to	34,028	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	494,683	equal to	544,448	-49,765	FAILED	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to	0	0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to	0	0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	15,324	equal to	15,324	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	18,238	equal to	18,238	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	81,451	equal to	81,451	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	17,387	equal to	17,387	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	46,443	equal to	46,443	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	34,841	equal to	34,841	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	51,329	equal to	51,329	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	127,793	equal to	127,793	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to	0	0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	937,254	equal to	937,254	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	4,586	< or = to	4,849	-263	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	6,900	< or = to	6,900	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	3,301	< or = to	3,556	-255	O.K.	Pg20 X14..X16+	B. & C.	37to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	1,795	< or = to	1,795	0	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	1,795	< or = to	1,795	0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	51,329	equal to	51,329	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	-40,717	equal to	-40,717	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	20,875	equal to	20,875	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	154,456	equal to	154,456	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	3,712	equal to	3,712	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	4,278	equal to	4,278	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	34,028	equal to	34,028	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	0	< or = to	8,879	-8,879	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	0	equal to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to	0	0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	744	equal to	744	0	O.K.	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	88,492	equal to	88,492	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4†	B.	14	8
Total loan balance	2,127,762	equal to	2,127,762	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	28,351	equal to	28,351	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	25,850	equal to	25,850	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	1,829,446	equal to	1,829,446	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	282,162	equal to	282,162	0	O.K.	Pg13 O22+L13	C. & D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	412,921	equal to	412,921	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	-1,893,725	equal to	-1,893,725	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	-251,704	equal to	-251,704	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to	0	0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	318,670	equal to	318,670	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustmen	Adjusted Total
1. Dietary	81,451	6,632	4,849	92,932	0	92,932	0	92,932
2. Food P	0	64,503	0	64,503	0	64,503	-200	64,303
3. Housek	46,443	6,520	0	52,963	0	52,963	0	52,963
4. Laundry	34,841	8,649	0	43,490	0	43,490	0	43,490
5. Heat ar	0	0	43,991	43,991	0	43,991	776	44,767
6. Mainte	17,387	0	29,760	47,147	0	47,147	44	47,191
7. Other (	0	0	0	0	0	0	0	0
8. Total G	180,122	86,304	78,600	345,026	0	345,026	620	345,646
9. Medical	0	0	6,900	6,900	0	6,900	0	6,900
10. Nursin	544,448	46,056	3,556	594,060	0	594,060	0	594,060
10a. Ther	0	0	120,029	120,029	0	120,029	0	120,029
11. Activi	15,324	2,875	1,795	19,994	0	19,994	0	19,994
12. Social	18,238	0	1,795	20,033	0	20,033	0	20,033
13. Nurse	0	0	0	0	0	0	0	0
14. Progr	0	0	1,661	1,661	0	1,661	0	1,661
15. Other	0	0	0	0	0	0	0	0
16. Total I	578,010	48,931	135,736	762,677	0	762,677	0	762,677
17. Admin	51,329	0	-40,717	10,612	0	10,612	40,717	51,329
18. Direct	0	0	0	0	0	0	0	0
19. Profes	0	0	20,875	20,875	0	20,875	15,729	36,604
20. Fees,	0	0	3,997	3,997	0	3,997	-285	3,712
21. Cleric	127,793	9,957	15,017	152,767	0	152,767	5,350	158,117
22. Emplo	0	0	145,577	145,577	0	145,577	8,879	154,456
23. Inserv	0	0	30	30	0	30	168	198
24. Travel	0	0	2,221	2,221	0	2,221	2,057	4,278
25. Other	0	0	1,201	1,201	0	1,201	0	1,201
26. Insura	0	0	32,831	32,831	0	32,831	4,705	37,536
27. Other	0	0	0	0	0	0	0	0
28. Total C	179,122	9,957	181,032	370,111	0	370,111	77,320	447,431
29. Total C	937,254	145,192	395,368	1,477,814	0	1,477,814	77,940	1,555,754
30. Depre	0	0	5,701	5,701	0	5,701	88,705	94,406
31. Amort	0	0	0	0	0	0	0	0
32. Intere	0	0	54,459	54,459	0	54,459	148,541	203,000
33. Real E	0	0	0	0	0	0	28,092	28,092
34. Rent -	0	0	276,000	276,000	0	276,000	-271,901	4,099
35. Rent -	0	0	4,174	4,174	0	4,174	3,845	8,019
36. Other	0	0	0	0	0	0	9,546	9,546
37. Total C	0	0	340,334	340,334	0	340,334	6,828	347,162
38. Medic	0	0	0	0	0	0	0	0
39. Ancill	0	22,604	0	22,604	0	22,604	0	22,604
40. Barbe	0	0	0	0	0	0	0	0
41. Coffee	0	0	0	0	0	0	0	0
42	0	0	34,028	34,028	0	34,028	0	34,028
43. Other	0	0	34,080	34,080	0	34,080	-34,080	0
44. Total S	0	22,604	68,108	90,712	0	90,712	-34,080	56,632
45. Grand	937,254	167,796	803,810	1,908,860	0	1,908,860	50,688	1,959,548

	After	Consolidation
General Service Cost Center		
1. Cash on	-37,733	109,816
2. Cash - F	0	0
3. Account	236,137	588,737
4. Supply I	0	0
5. Short-T	0	0
6. Prepaid	33,168	32,982
7. Other Pi	12,589	14,125
8. Account	0	0
9. Other (s	46,112	45,840
10. Total c	290,273	791,500
LONG TERM ASSETS		
11. Long-T	0	0
12. Long-T	0	0
13. Land	0	25,850
14. Buildin	16,687	1,828,446
15. Lease	1,000	1,000
16. Equipn	35,478	282,162
17. Accum	-24,768	-412,921
18. Deferre	0	0
19. Organi	0	0
20. Accum	0	0
21. Restric	0	0
22. Other I	0	94,034
23. other (:	0	0
24. Total L	28,397	1,818,571
25. Total A	318,670	2,610,071
CURRENT LIABILITIES		
26. Accour	727,619	767,844
27. Officer	0	0
28. Accour	0	0
29. Short-T	0	0
30. Accrue	46,955	46,955
31. Accrue	3,421	3,421
32. Accrue	0	28,351
33. Accrue	0	0
34. Deferre	0	0
35. Federa	0	0
36. Other (	1,149,384	1,256,299
37. Other (	0	0
38. Total C	1,927,379	2,102,870
LONG TERM LIABILITES		
39. Long-T	72,282	72,951
40. Mortga	212,734	2,054,811
41. Bonds I	0	0
42. Deferre	0	0
43. Other L	0	0
44. Other L	0	0
45. Total L	285,016	2,127,762
46. Total Li	2,212,395	4,230,632
47. Total E	#####	#####
48. Total Li	318,670	2,610,071

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	1,485,456
2. Discounts and Allowances for all Levels	-62,077
Subtotal - Inpatient Care	1,423,379
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	196,582
7. Oxygen	0
Subtotal - Ancillary Revenue	196,582
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	200
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	33,905
18. Sale of Supplies to Non-Patients	0
19. Laboratory	488
20. Radiology and X-Ray	0
21. Other Medical Services	2,092
22. Laundry	0
Subtotal - Other Operating Revenue	36,685
24. Contributions	500
25. Interest and Other Investments Income	0
Subtotal - Non-Operating Revenue	500
27. Other Revenue (specify):	10
28. Other Revenue (specify):	0
Subtotal - Other Revenue	10
30. Total Revenue	1,657,156
31. General Services	345,026
32. Health Care	762,677
33. General Administration	370,111
34. Ownership	340,334
35. Special Cost Centers	56,684
35. Provider Participation Fee	34,028
37. Other	0
40. Total Expenses	1,908,860
41. Income Before Income Taxes	-251,704
42. Income Taxes	0
43. Net Income or Loss for the Year	-251,704

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9 Line 16 for mortgage insurance.

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